Friday,
May 4, 2007

Part V

Department of Health and Human Services

Centers for Medicare and Medicaid Services

Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System Payment Update for Rate Year Beginning July 1, 2007 (RY 2008); Notice
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1479–N]

RIN 0938–AO40

Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System Payment Update for Rate Year Beginning July 1, 2007 (RY 2008)

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice.

SUMMARY: This notice updates the prospective payment rates for Medicare inpatient psychiatric hospital services provided by inpatient psychiatric facilities (IPFs). These changes are applicable to IPF discharges occurring during the rate year beginning July 1, 2007 through June 30, 2008.

EFFECTIVE DATE: The updated IPF prospective payment rates are effective for discharges occurring on or after July 1, 2007 through June 30, 2008.

FOR FURTHER INFORMATION CONTACT: Dorothy Myrick or Jana Lindquist, (410) 786–4533 (for general information).

Heidi Oumarou, (410) 786–7942 (for information regarding the market basket and labor-related share).

Theresa Bean, (410) 786–2287 (for information regarding the regulatory impact analysis).

Matthew Quarrick, (410) 786–9867 (for information on the wage index).

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Acronyms

Because of the many terms to which we refer by acronym in this notice, we are listing the acronyms used and their corresponding terms in alphabetical order below:

CBSA Core-Based Statistical Area
CCR Cost-to-charge ratio
CMSA Consolidated Metropolitan Statistical Area
DSM–IV–TR Diagnostic and Statistical Manual of Mental Disorders Fourth Edition—Text Revision
ICD–9–CM International Classification of Diseases, 9th Revision, Clinical Modification
IPFs Inpatient psychiatric facilities
IRFs Inpatient rehabilitation facilities
LTCHS Long-term care hospitals
MedPAR Medicare provider analysis and review file
MSA Metropolitan Statistical Area
RY Rate Year

Register (69 FR 66922). In developing the IPF PPS, in order to ensure that the IPF PPS is able to account adequately for each IPF’s case-mix, we performed an extensive regression analysis of the relationship between the per diem costs and certain patient and facility characteristics to determine those characteristics associated with statistically significant cost differences on a per diem basis. For characteristics with statistically significant cost differences, we used the regression coefficients of those variables to determine the size of the corresponding payment adjustments.

In that final rule, we explained that we believe it is important to delay updating the adjustment factors derived from the regression analysis until we have IPF PPS data that includes as much information as possible regarding the patient-level characteristics of the population that each IPF serves.

Therefore, we indicated that we did not intend to update the regression analysis and recalculate the Federal per diem base rate and the patient- and facility-level adjustment until we complete that analysis. Until that analysis is complete, we stated our intention to publish a notice in the Federal Register each spring to update the IPF PPS (71 FR 27041).

Updates to the IPF PPS as specified in 42 CFR 412.428 include:

• A description of the methodology and data used to calculate the updated Federal per diem base payment amount.
• The rate of increase factor as described in § 412.424(a)(2)(iii), which is based on the excluded hospital with capital market basket under the update methodology of section 1886(b)(3)(B)(ii) of the Act for each year.
• For discharges occurring on or after July 1, 2006, the rate of increase factor for the Federal portion of the IPF’s payment, which is based on the rehabilitation, psychiatric, and long-term care (RPL) market basket.
• For discharges occurring on or after October 1, 2005, the rate of increase factor for the reasonable cost portion of the IPF’s payment, which is based on the 2002-based excluded hospital market with capital basket.
• The best available hospital wage index and information regarding whether an adjustment to the Federal per diem base rate, which is needed to maintain budget neutrality.
• Updates to the fixed dollar loss threshold amount in order to maintain the appropriate outlier percentage.
• Description of the ICD–9–CM coding and DRG classification changes discussed in the annual update to the hospital
inpatient prospective payment system (IPPS) regulations.
- Update to the electroconvulsive therapy (ECT) payment by a factor specified by CMS.
- Update to the national urban and rural cost to charge ratio medians and ceilings.
- Update to the cost of living adjustment factors for IPFs located in Alaska and Hawaii if appropriate.

Our most recent annual update occurred in a final rule (71 FR 27040, May 9, 2006) that set forth updates to the IPF PPS payment rates for FY 2007. We subsequently published a correction notice (71 FR 37505, June 30, 2006) with respect to those payment rate updates.

This notice does not initiate any policy changes with regard to the IPF PPS; rather, it simply provides an update to the rates for FY 2008 (that is, the prospective payment rates applicable for discharges beginning July 1, 2007 through June 30, 2008). In establishing these payment rates, we update the IPF per diem payment rates that were published in the May 2006 IPF PPS final rule in accordance with our established policies.

B. Overview of the Legislative Requirements for the IPF PPS

Section 124 of the BBRA required implementation of the IPF PPS. Specifically, section 124 of the BBRA mandated that the Secretary develop a per diem PPS for inpatient hospital services furnished in psychiatric hospitals and psychiatric units that includes in the PPS an adequate patient classification system that reflects the differences in patient resource use and costs among psychiatric hospitals and psychiatric units.

Section 405(g)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173) extended the IPF PPS to psychiatric units of critical access hospitals (CAHs).

To implement these provisions, we published various proposed and final rules in the Federal Register. For more information regarding these rules, see the CMS websites http://www.cms.hhs.gov/InpatientPsychFacilIPPS/ and www.cms.hhs.gov/InpatientpsychfacilIPPS/02_regulations.asp.

C. IPF PPS—General Overview

The November 2004 IPF PPS final rule (69 FR 66922) established the IPF PPS, as authorized under section 124 of the BBRA and codified at subpart N of part 412 of the Medicare regulations. The November 2004 IPF PPS final rule set forth the per diem Federal rates for the implementation year (that is, the 18-month period from January 1, 2005 through June 30, 2006) that provided payment for the inpatient operating and capital costs to IPF’s for covered psychiatric services they furnish (that is, routine, ancillary, and capital costs), but not costs of approved educational activities, bad debts, and other services or items that are outside the scope of the IPF PPS. Covered psychiatric services include services for which benefits are provided under the fee-for-service Part A (Hospital Insurance Program) Medicare program.

The IPF PPS established the Federal per diem base rate for each patient day in an IPF derived from the national average daily routine operating, ancillary, and capital costs in IPFs in FY 2002. The average per diem cost was updated to the midpoint of the first year under the IPF PPS, standardized to account for the overall positive effects of the IPF PPS payment adjustments, and adjusted for budget neutrality. The Federal per diem payment under the IPF PPS is comprised of the Federal per diem base rate described above and certain patient- and facility-level payment adjustments that were found in the regression analysis to be associated with statistically significant per diem cost differences.

The patient-level adjustments include age, DRG assignment, comorbidities, and variable per diem adjustments to reflect a higher per diem cost in the early days of a psychiatric stay. Facility-level adjustments include adjustments for the IPF’s wage index, rural location, teaching status, a cost of living adjustment for IPFs located in Alaska and Hawaii, and presence of a qualifying emergency department (ED).

The IPF PPS provides additional payments for: outlier cases; stop-loss protection (which is applicable only during the IPF PPS transition period); interrupted stays; and a per treatment adjustment for patients who undergo ECT.

A complete discussion of the regression analysis appears in the November 2004 IPF PPS final rule (69 FR 66933 through 66936).

Section 124 of Medicare, Medicaid and SCHIP (State Children’s Health Insurance Program) Balanced Budget Refinement Act of 1999, (Pub. L. 106–113) (BBRA) does not specify an annual update rate strategy for the IPF PPS and is broadly written to give the Secretary discretion in establishing an update methodology. Therefore, in the November 2004 IPF PPS final rule (69 FR 66966), we implemented the IPF PPS using the following update strategy—

1. Calculate the final Federal per diem base rate to be budget neutral for the 18-month period of January 1, 2005 through June 30, 2006;
2. (2) use a July 1 through June 30 annual update cycle; and
3. (3) allow the IPF PPS first update to be effective for discharges on or after July 1, 2006 through June 30, 2007.

II. Transition Period for Implementation of the IPF PPS

In the November 2004 IPF PPS final rule, we established § 412.426 to provide for a 3-year transition period from reasonable cost-based reimbursement to full prospective payment for IPFs. The purpose of the transition period is to allow existing IPFs time to adjust their cost structures and to integrate the effects of changing to the IPF PPS.

New IPFs, as defined in § 412.426(c), are paid 100 percent of the Federal per diem payment amount. For those IPFs that are transitioning to the new system, payment is based on an increasing percentage of the PPS payment and a decreasing percentage of each IPF’s facility-specific Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) reimbursement rate.

<table>
<thead>
<tr>
<th>Transition year</th>
<th>Cost reporting periods beginning on or after</th>
<th>TEFRA rate percentage</th>
<th>IPF PPS federal rate percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>January 1, 2005</td>
<td>75</td>
<td>25</td>
</tr>
<tr>
<td>2</td>
<td>January 1, 2006</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>3</td>
<td>January 1, 2007</td>
<td>25</td>
<td>75</td>
</tr>
<tr>
<td></td>
<td>January 1, 2008</td>
<td>0</td>
<td>100</td>
</tr>
</tbody>
</table>
Changes to the blend percentages occur at the beginning of an IPF’s cost reporting period. However, regardless of when an IPF’s cost reporting year begins, the payment update will be effective for discharges occurring on or after July 1, 2007 through June 30, 2008. We are currently in the third year of the transition period. As a result, for discharges occurring during IPF cost reporting periods beginning in calendar year (CY) 2007, IPFs would receive a blended payment consisting of 25 percent of the facility-specific TEFRA payment and 75 percent of the IPF PPS payment amount.

For FY 2008, we are not making any changes to the transition period established in the November 2004 IPF PPS final rule.

III. Updates to the IPF PPS for RY Beginning July 1, 2007

The IPF PPS is based on a standardized Federal per diem base rate calculated from FY 2002 IPF average costs per day and adjusted for budget-neutrality and updated to the midpoint of the implementation year. The Federal per diem base rate is used as the standard payment per day under the IPF PPS and is adjusted by the applicable wage index factor and the patient-level and facility-level adjustments that are applicable to the IPF stay.

A detailed explanation of how we calculated the average per diem cost appears in the November 2004 IPF PPS final rule (69 FR 66926).

A. Determining the Standardized Budget-Neutral Federal Per Diem Base Rate

Section 124(a)(1) of the BBRA requires that we implement the IPF PPS in a budget neutral manner. In other words, the amount of total payments under the IPF PPS, including any payment adjustments, must be projected to be equal to the amount of total payments that would have been made if the IPF PPS were not implemented. Therefore, we calculated the budget-neutrality factor by setting the total estimated IPF PPS payments to be equal to the total estimated payments that would have been made under the TEFRA methodology had the IPF PPS not been implemented.

For the IPF PPS methodology, we calculated the final Federal per diem base rate to be budget neutral during the IPF PPS implementation period (that is, the 18-month period from January 1, 2005 through June 30, 2006) using a July 1 update cycle.

We updated the average per diem cost to the midpoint of the IPF PPS implementation period (that is, October 1, 2005), and this amount was used in the payment model to establish the budget-neutrality adjustment.

A step-by-step description of the methodology used to estimate payments under the TEFRA payment system appears in the November 2004 IPF PPS final rule (69 FR 66926).

1. Standardization of the Federal Per Diem Base Rate and Electroconvulsive Therapy Rate

In the November 2004 IPF PPS final rule, we describe how we standardized the IPF PPS Federal per diem base rate in order to account for the overall positive effects of the IPF PPS payment adjustment factors. To standardize the IPF PPS payments, we compared the IPF PPS payment amounts calculated from the FY 2002 Medicare Provider Analysis and Review (MedPAR) file to the projected TEFRA payments from the FY 2002 cost report file updated to the midpoint of the IPF PPS implementation period (that is, October 2005). The standardization factor was calculated by dividing total estimated payments under the TEFRA payment system by estimated payments under the IPF PPS. The standardization factor was calculated to be 0.8367.

As described in detail in the May 2006 IPF PPS final rule (71 FR 27045), in reviewing the methodology used to simulate the IPF PPS payments used for the November 2004 IPF PPS final rule, we discovered that due to a computer code error, total IPF PPS payments were underestimated by about 1.36 percent. Since the IPF PPS payment total should have been larger than the estimated figure, the standardization factor should have been smaller (0.8254 vs. 0.8367). In turn, the Federal per diem base rate and the ECT rate should have been reduced by 0.8254 instead of 0.8367.

To resolve this issue, in RY 2007, we amended the Federal per diem base rate and the ECT payment rate prospectively. Using the standardization factor of 0.8254, the average cost per day was effectively reduced by 17.46 percent (100 percent minus 82.54 percent = 17.46 percent).

2. Calculation of the Budget Neutrality Adjustment

To compute the budget neutrality adjustment for the IPF PPS, we separately identified each component of the adjustment, that is, the outlier adjustment, stop-loss adjustment, and behavioral offset.

A complete discussion of how we calculate each component of the budget neutrality adjustment appears in the November 2004 IPF PPS final rule (69 FR 66932 through 66933) and the May 2006 IPF PPS final rule (71 FR 27044 through 27046).

a. Outlier Adjustment

Since the IPF PPS payment amount for each IPF includes applicable outlier amounts, we reduced the standardized Federal per diem base rate to account for aggregate IPF PPS payments estimated to be made as outlier payments. The outlier adjustment was calculated to be 2 percent. As a result, the standardized Federal per diem base rate was reduced by 2 percent to account for projected outlier payments.

b. Stop-Loss Provision Adjustment

As explained in the November 2004 IPF PPS final rule, we provide a stop-loss payment to ensure that an IPF’s total PPS payments are no less than a minimum percentage of their TEFRA payment, had the IPF PPS not been implemented. We reduced the standardized Federal per diem base rate by the percentage of aggregate IPF PPS payments estimated to be made for stop-loss payments. As a result, the standardized Federal per diem base rate was reduced by 0.39 percent to account for stop-loss payments.

c. Behavioral Offset

As explained in the November 2004 IPF PPS final rule, implementation of the IPF PPS may result in certain changes in IPF practices especially with respect to coding for comorbid medical conditions. As a result, Medicare may make higher payments than assumed in our calculations. Accounting for these effects through an adjustment is commonly known as a behavioral offset.

Based on accepted actuarial practices and consistent with the assumptions made in other PPSs, we assumed in determining the behavioral offset that IPFs would regain 15 percent of potential “losses” and augment payment increases by 5 percent. We applied this actuarial assumption, which is based on our historical experience with new payment systems, to the estimated “losses” and “gains” among the IPFs. The behavioral offset for the IPF PPS was calculated to be 2.66 percent. As a result, we reduced the standardized Federal per diem base rate by 2.66 percent to account for behavioral changes. As indicated in the November 2004 IPF PPS final rule, we do not plan to change adjustment factors or projections, including the behavioral offset, until we analyze IPF PPS data. At that time, we will re-assess the accuracy of the behavioral offset along with the other factors impacting budget neutrality.
If we find that an adjustment is warranted, the percent difference may be applied prospectively to the established PPS rates to ensure the rates accurately reflect the payment level intended by the statute. In conducting this analysis, we will be interested in the extent to which improved documentation and coding of patients’ primary and other diagnoses, which may not reflect real increases in underlying resource demands, has occurred under the PPS.

B. Update of the Federal Per Diem Base Rate and Electroconvulsive Therapy Rate

1. Market Basket for IPFs Reimbursed Under the IPF PPS

As described in the November 2004 IPF PPS final rule, the average per diem cost was updated to the midpoint of the implementation year (69 FR 66931). This updated average per diem cost of $724.43 was reduced by 17.46 percent to account for standardization to projected TEFRA payments for the implementation period, by 2 percent to account for outlier payments, by 0.39 percent to account for stop-loss payments, and by 2.66 percent to account for the behavioral offset. The Federal per diem base rate in the implementation year was $575.95, and for RY 2007, it was $595.09.

Applying the market basket increase of 3.2 percent and the wage index budget neutrality factor of 1.0014 yields a Federal per diem base rate of $614.99 for RY 2008. Similarly, applying the market basket increase and wage index budget neutrality factor to the RY 2007 ECT rate yields an ECT rate of $264.77 for RY 2008.

a. Market Basket Index for the IPF PPS

The market basket index that was used to develop the IPF PPS was the excluded hospital with capital market basket. The market basket was based on 1997 Medicare cost report data and included data for Medicare participating IRFs, inpatient rehabilitation facilities (IRFs), long-term care hospitals (LTCHs), cancer, and children’s hospitals.

We are presently unable to create a separate market basket specifically for psychiatric hospitals due to the following two reasons: (1) There is a very small sample size for free-standing psychiatric facilities; and (2) there are limited expense data for some categories on the free-standing psychiatric cost reports (for example, approximately 4 percent of free-standing psychiatric facilities reported contract labor cost data for FY 2002). However, since all IRFs, LTCHs, and IPFs are now paid under a PPS, we are updating PPS payments made under the IRF PPS, the LTCH PPS, and the IPF PPS using a market basket reflecting the operating and capital cost structures for IRFs, IPFs, and LTCHs (hereafter referred to as the rehabilitation, psychiatric, long-term care (RPL) market basket).

We have excluded cancer and children’s hospitals from the RPL market basket because their payments are based entirely on reasonable costs subject to rate-of-increase limits established under the authority of section 1886(b) of the Act, which are implemented in regulations at § 413.40. They are not reimbursed under a PPS. Also, the FY 2002 cost structures for cancer and children’s hospitals are noticeably different than the cost structures of the IRFs, IPFs, and LTCHs.

The services offered in IRFs, IPFs, and LTCHs are typically more labor-intensive than those offered in cancer and children’s hospitals. Therefore, the compensation cost weights for IRFs, IPFs, and LTCHs are larger than those in cancer and children’s hospitals. In addition, the depreciation cost weights for IRFs, IPFs, and LTCHs are noticeably smaller than those for cancer and children’s hospitals.

A complete discussion of the RPL market basket appears in the May 2006 IPF PPS final rule (71 FR 27046 through 27054).

b. Overview of the RPL Market Basket

The RPL market basket is a fixed weight, Laspeyres-type price index. A market basket is described as a fixed-weight index because it answers the question of how much it would cost, at another time, to purchase the same mix of goods and services purchased to provide hospital services in a base period. The effects on total expenditures resulting from changes in the quantity or mix of goods and services (intensity) purchased subsequent to the base period are not measured. In this manner, the market basket measures only pure price change. Only when the index is rebased would the quantity and intensity effects be captured in the cost weights.

Therefore, we rebase the market basket periodically so that cost weights reflect changes in the mix of goods and services that hospitals purchase (hospital inputs) to furnish patient care between base periods.

The terms rebasing and revising, while often used interchangeably, actually denote different activities. Rebasing means moving the base year for the structure of costs of an input price index (for example, shifting the base year cost structure from FY 1997 to FY 2002). Revising means changing data sources, methodology, or price proxies used in the input price index. In 2006 we rebased and revised the market basket used to update the IPF PPS.

Table 2 below sets forth the completed 2002-based RPL market basket including the cost categories, weights, and price proxies.

BILLING CODE 4120-01-P
### Table 2--FY 2002-based RPL Market Basket Cost Categories, Weights, and Proxies

<table>
<thead>
<tr>
<th>Expense Categories</th>
<th>FY 2002-based RPL Market Basket</th>
<th>FY 2002 RPL Market Basket Price Proxies</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL</td>
<td>100.000</td>
<td></td>
</tr>
<tr>
<td>Compensation</td>
<td>65.877</td>
<td></td>
</tr>
<tr>
<td>Wages and Salaries*</td>
<td>52.895</td>
<td>ECI-Wages and Salaries, Civilian Hospital Workers</td>
</tr>
<tr>
<td>Employee Benefits*</td>
<td>12.982</td>
<td>ECI-Benefits, Civilian Hospital Workers</td>
</tr>
<tr>
<td>Professional Fees, Non-Medical*</td>
<td>2.892</td>
<td>ECI-Compensation for Professional, Specialty &amp; Technical Workers</td>
</tr>
<tr>
<td>Utilities</td>
<td>0.656</td>
<td></td>
</tr>
<tr>
<td>Electricity</td>
<td>0.351</td>
<td>PPI-Commercial Electric Power</td>
</tr>
<tr>
<td>Fuel Oil, Coal, etc.</td>
<td>0.108</td>
<td>PPI-Commercial Natural Gas</td>
</tr>
<tr>
<td>Water and Sewage</td>
<td>0.197</td>
<td>CPI-U – Water &amp; Sewage Maintenance</td>
</tr>
<tr>
<td>Professional Liability Insurance</td>
<td>1.161</td>
<td>CMS Professional Liability Premium Index</td>
</tr>
<tr>
<td>All Other Products and Services</td>
<td>19.265</td>
<td></td>
</tr>
<tr>
<td>All Other Products</td>
<td>13.323</td>
<td></td>
</tr>
<tr>
<td>Pharmaceuticals</td>
<td>5.103</td>
<td>PPI Prescription Drugs</td>
</tr>
<tr>
<td>Food: Direct Purchase</td>
<td>0.873</td>
<td>PPI Processed Foods &amp;</td>
</tr>
</tbody>
</table>
For RY 2008, we evaluated the price proxies using the criteria of reliability, timeliness, availability, and relevance. **Reliability** indicates that the index is based on valid statistical methods and has low sampling variability. **Timeliness** implies that the proxy is published regularly, preferably at least once a quarter. **Availability** means that the proxy is publicly available. Finally, **relevance** means that the proxy is applicable and representative of the cost category weight to which it is applied. The Consumer Price Indexes (CPIs), Producer Price Indexes (PPIs), and Employment Cost Indexes (ECIs) used as proxies in this market basket meet these criteria.

We note that the proxies are the same as those used for the FY 1997-based excluded hospital with capital market basket. Because these proxies meet our criteria of reliability, timeliness, availability, and relevance, we believe they continue to be the best measure of price changes for the cost categories. For further discussion on the FY 1997-based excluded hospital with capital market basket, see the August 1, 2002 IPPS final rule (67 FR at 50042).

The RY 2008 (that is, beginning July 1, 2007) update for the IPF PPS using

<table>
<thead>
<tr>
<th>Expense Categories</th>
<th>FY 2002-based RPL Market Basket</th>
<th>FY 2002 RPL Market Basket Price Proxies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeds</td>
<td>0.620</td>
<td>CPI-U Food Away From Home</td>
</tr>
<tr>
<td>Chemicals</td>
<td>1.100</td>
<td>PPI Industrial Chemicals</td>
</tr>
<tr>
<td>Medical Instruments</td>
<td>1.014</td>
<td>PPI Medical Instruments &amp; Equipment</td>
</tr>
<tr>
<td>Photographic Supplies</td>
<td>0.096</td>
<td>PPI Photographic Supplies</td>
</tr>
<tr>
<td>Rubber and Plastics</td>
<td>1.052</td>
<td>PPI Rubber &amp; Plastic Products</td>
</tr>
<tr>
<td>Paper Products</td>
<td>1.000</td>
<td>PPI Converted Paper &amp; Paperboard Products</td>
</tr>
<tr>
<td>Apparel</td>
<td>0.207</td>
<td>PPI Apparel</td>
</tr>
<tr>
<td>Machinery and Equipment</td>
<td>0.297</td>
<td>PPI Machinery &amp; Equipment</td>
</tr>
<tr>
<td>Miscellaneous Products**</td>
<td>1.963</td>
<td>PPI Finished Goods less Food &amp; Energy</td>
</tr>
<tr>
<td>All Other Services</td>
<td>5.942</td>
<td>CPI-U Telephone Services</td>
</tr>
<tr>
<td>Telephone</td>
<td>0.240</td>
<td>CPI-U Telephone Services</td>
</tr>
<tr>
<td>Postage</td>
<td>0.682</td>
<td>CPI-U Postage</td>
</tr>
<tr>
<td>All Other: Labor Intensive</td>
<td>2.219</td>
<td>ECI-Compensation for Private Service Occupations</td>
</tr>
<tr>
<td>All Other: Non-labor Intensive</td>
<td>2.800</td>
<td>CPI-U All Items</td>
</tr>
<tr>
<td>Capital-Related Costs</td>
<td>10.149</td>
<td>Boeckh Institutional Construction 23-year useful life</td>
</tr>
<tr>
<td>Depreciation</td>
<td>6.186</td>
<td>WPI Machinery &amp; Equipment 11-year useful life</td>
</tr>
<tr>
<td>Fixed Assets</td>
<td>4.250</td>
<td>Average yield on domestic municipal bonds (Bond Buyer 20 bonds) vintage-weighted (23 years)</td>
</tr>
<tr>
<td>Movable Equipment</td>
<td>1.937</td>
<td>Average yield on Moody's Aaa bond vintage-weighted (23 years)</td>
</tr>
<tr>
<td>Interest Costs</td>
<td>2.775</td>
<td></td>
</tr>
<tr>
<td>Nonprofit</td>
<td>2.081</td>
<td></td>
</tr>
<tr>
<td>For Profit</td>
<td>0.694</td>
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</tr>
<tr>
<td>Other Capital-Related Costs</td>
<td>1.187</td>
<td>CPI-U Residential Rent</td>
</tr>
</tbody>
</table>

* Labor-related
** Blood and blood-related products is included in miscellaneous products

NOTE: Due to rounding, weights may not sum to total.
the FY 2002-based RPL market basket and Global Insight’s 1st quarter 2007 forecast for the market basket components is 3.2 percent. This includes increases in both the operating section and the capital section for the 12-month RY period (that is, July 1, 2007 through June 30, 2008). Global Insight, Inc. is a nationally recognized economic and financial forecasting firm that contracts with CMS to forecast the components of the market baskets.

2. Labor-Related Share

Due to the variations in costs and geographic wage levels, we believe that payment rates under the IPF PPS should continue to be adjusted by a geographic wage index. This wage index applies to the labor-related portion of the Federal per diem base rate, hereafter referred to as the labor-related share.

The labor-related share is determined by identifying the national average proportion of operating costs that are related to, influenced by, or vary with the local labor market. Using our current definition of labor-related, the labor-related share is the sum of the relative importance of wages and salaries, fringe benefits, professional fees, labor-intensive services, and a portion of the capital share from an appropriate market basket. We used the FY 2002-based RPL market basket costs to determine the labor-related share for the IPF PPS.

The labor-related share for FY 2008 is the sum of the FY 2008 relative importance of each labor-related cost category, and reflects the different rates of price change for these cost categories between the base year (FY 2002) and FY 2008. The sum of the relative importance for the FY 2008 operating costs (wages and salaries, employee benefits, professional fees, and labor-intensive services) is 71.767, as shown in Table 3 below. The portion of capital that is influenced by the local labor market is estimated to be 46 percent, which is the same percentage used in the FY 1997-based IRF and IPF payment systems.

Since the relative importance for capital is 8.742 percent of the FY 2002-based RPL market basket in FY 2008, we are taking 46 percent of 8.742 percent to determine the labor-related share of capital for FY 2008. The result is 4.021 percent, which we added to 71.767 percent for the operating cost amount to determine the total labor-related share for FY 2008. Thus, the labor-related share that we are using for IPF PPS in FY 2008 is 75.788 percent. Table 3 below shows the FY 2008 relative importance of labor-related shares using the FY 2002-based RPL market basket. We note that this labor-related share is determined by using the same methodology as employed in calculating all previous IPF labor-related shares.

A complete discussion of the IPF labor-related methodology appears in the November 2004 IPF PPS final rule (69 FR 66952 through 66954).

### Table 3.—TOTAL LABOR-RELATED SHARE—RELATIVE IMPORTANCE FOR RY 2008

<table>
<thead>
<tr>
<th>Cost category</th>
<th>FY 2002-based RPL market basket relative importance (Percent) FY 2007</th>
<th>FY 2002 RPL market basket relative importance (Percent) RY 2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wages and salaries</td>
<td>52.506</td>
<td>52.588</td>
</tr>
<tr>
<td>Employee benefits</td>
<td>14.042</td>
<td>14.127</td>
</tr>
<tr>
<td>Professional fees</td>
<td>2.886</td>
<td>2.907</td>
</tr>
<tr>
<td>All other labor-intensive services</td>
<td>2.152</td>
<td>2.145</td>
</tr>
<tr>
<td>Subtotal</td>
<td>71.586</td>
<td>71.767</td>
</tr>
<tr>
<td>Labor-related share of capital costs</td>
<td>4.079</td>
<td>4.021</td>
</tr>
<tr>
<td>Total</td>
<td>75.665</td>
<td>75.788</td>
</tr>
</tbody>
</table>

3. IPFs Paid Based on a Blend of the Reasonable Cost-Based Payments

As stated in the FY 2006 IPPS final rule (70 FR 47399), for IPFs that are transitioning to the fully Federal prospective payment rate, we are now using the rebased and revised FY 2002-based excluded hospital market basket to update the reasonable cost-based portion of their payments.

We chose FY 2002 as the base year for the excluded hospital market basket because this was the most recent, complete year of Medicare cost report data.

The reasonable cost-based payments, subject to TEFRA limits, are determined on a FY basis. The FY 2008 update factor for the portion of the IPF PPS transitional blend payment based on reasonable costs will be published in the FY 2008 IPPS proposed and final rules.

### IV. Update of the IPF PPS Adjustment Factors

A. Overview of the IPF PPS Adjustment Factors

The IPF PPS payment adjustments were derived from a regression analysis of 100 percent of the FY 2002 MedPAR data file, which contained 483,038 cases. We used the same results of this regression analysis to implement the November 2004 and May 2006 IPF PPS final rules. We also use the same results of this regression analysis to update the IPF PPS for FY 2008.

As previously stated, we do not plan to update the regression analysis until we analyze IPF PPS data. We plan to monitor claims and payment data independently from cost report data to assess issues, or whether changes in case-mix or payment shifts have occurred between free standing governmental, non-profit, and private psychiatric hospitals, and psychiatric units of general hospitals, and other issues of importance to psychiatric facilities.

A complete discussion of the data file used for the regression analysis appears in the November 2004 IPF PPS final rule (69 FR 66935 through 66936).

B. Patient-Level Adjustments

In the May 2006 IPF PPS final rule (71 FR 27040) for FY 2007, we provided payment adjustments for the following patient-level characteristics: DRG assignment of the patient’s principal diagnosis; selected comorbidities; patient age; and the variable per diem adjustments. As previously stated in the November 2004 IPF PPS final rule, we do not intend to update the adjustment factors derived from the regression analysis until we have IPF PPS data that includes as much information as possible regarding the patient-level
1. Adjustment for DRG Assignment

The IPF PPS includes payment adjustments for the psychiatric DRG assigned to the claim based on each patient’s principal diagnosis. In the May 2006 IPF PPS final rule (71 FR 27040), we explained that the IPF PPS includes 15 diagnosis-related group (DRG) adjustment factors. The adjustment factors were expressed relative to the most frequently reported psychiatric DRG in FY 2002, that is, DRG 430 (psychoses). The coefficient values and adjustment factors were derived from the regression analysis.

In accordance with §412.27, payment under the IPF PPS is made for claims with a principal diagnosis included in the Diagnostic and Statistical Manual of Mental Disorder-Fourth Edition-Text Revision (DSM–IV–TR) or Chapter Five of the International Classification of Diseases-9th Revision-Clinical Modifications (ICD–9–CM).

The Standards for Electronic Transaction final rule published in the Federal Register on August 17, 2000 (65 FR 50312), adopted the ICD–9–CM as the designated code set for reporting diseases, injuries, impairments, other health related problems, their manifestations, and causes of injury, disease, impairment, or other health related problems.

IPF claims with a principal diagnosis included in Chapter Five of the ICD–9–CM or the DSM–IV–TR will be paid the Federal per diem base rate under the IPF PPS, all other applicable adjustments, and a DRG adjustment. Psychiatric principal diagnoses that do not group to one of the 15 designated DRGs receive the Federal per diem base rate and all other applicable adjustments, but the payment would not include a DRG adjustment.

We continue to believe that it is vital to maintain the same diagnostic coding and DRG classification for IPFs that is used under the IPPS for providing the same psychiatric care. All changes to the ICD–9–CM coding system that would impact the IPF PPS are addressed in the IPPS proposed and final rules published each year. The updated codes are effective October 1 of each year and must be used to report diagnostic or procedure information.


Further information concerning the official version of the ICD–9–CM can be found in the IPPS final regulation, “Revision to Hospital Inpatient Prospective Payment Systems—2007 FY Occupational Mix Adjustment to Wage Index Implementation; Final Rule,” in the August 18, 2006 Federal Register (71 FR 47870) and at http://www.cms.hhs.gov/QuarterlyProviderUpdates/Downloads/CMS1488F.pdf.

The three tables below list the FY 2007 new ICD–9–CM diagnosis codes, the one FY 2007 revised diagnosis code title, and the one invalid FY 2007 ICD diagnosis code, respectively, that group to one of the 15 DRGs for which the IPF PPS provides an adjustment. These tables are only a listing of FY 2007 changes and do not reflect all of the currently valid and applicable ICD–9–CM codes classified in the DRGs.

Table 4 below lists the new FY 2007 ICD–9–CM diagnosis codes that are classified to one of the 15 DRGs that are provided a DRG adjustment in the IPF PPS. When coded as a principal code or diagnosis, these codes receive the correlating DRG adjustment.

Table 5 below lists the invalid ICD–9–CM diagnosis code whose title has been modified in FY 2007. Title changes do not impact the DRG adjustment. When used as a principal diagnosis, these codes still receive the correlating DRG adjustment.

Table 6 below lists the invalid ICD–9–CM diagnosis code no longer applicable for the DRG adjustment in FY 2007.

Since we do not plan to update the regression analysis until we analyze IPF PPS data, the DRG adjustments factors, shown in Table 7, will continue to be paid for FY 2008.

2. Payment for Comorbid Conditions

The intent of the comorbidity adjustment is to recognize the increased cost associated with comorbid conditions by providing additional payments for certain concurrent medical or psychiatric conditions that are expensive to treat.

In the May 2006 IPF PPS final rule, we established 17 comorbidity categories and identified the ICD–9–CM diagnosis codes that generate a payment adjustment under the IPF PPS.

Comorbidities are specific patient conditions that are secondary to the patient’s principal diagnosis, and that require treatment during the stay. Diagnoses that relate to an earlier episode of care and have no bearing on the current hospital stay are excluded and should not be reported on IPF claims. Comorbid conditions must exist at the time of admission or develop subsequently, and affect the treatment received, affect the length of stay (LOS) or affect both treatment and LOS.

For each claim, an IPF may receive only one comorbidity adjustment per comorbidity category, but it may receive an adjustment for more than one comorbidity category. Billing instructions require that IPFs must enter the full ICD–9–CM codes for up to 8 additional diagnoses if they co-exist at the time of admission or develop subsequently.

The comorbidity adjustments were determined based on the regression analysis using the diagnoses reported by hospitals in FY 2002. The principal diagnoses were used to establish the DRG adjustment and were not accounted for in establishing the comorbidity category adjustments, except where ICD–9–CM “code first” instructions apply. As we explained in the May 2006 IPF PPS final rule (71 FR 27040), the code first rule applies when a condition has both an underlying
etiology and a manifestation due to the underlying etiology. For these conditions, the ICD–9–CM has a coding convention that requires the underlying conditions to be sequenced first followed by the manifestation. Whenever a combination exists, there is a “use additional code” note at the etiology code and a “code first” note at the manifestation code.

Although we are updating the IPF PPS to reflect updates to the ICD–9–CM codes, the comorbidity adjustment factors currently in effect will remain in effect for RY 2008. As previously stated, we do not plan to update the regression analysis until we analyze IPF PPS data. The comorbidity adjustments are shown in Table 8 below.

As previously discussed in the DRG section, we believe it is essential to maintain the same diagnostic coding set for IPFs that is used under the IPPS for providing the same psychiatric care. Therefore, in this update notice, we are continuing to use the most current FY 2007 ICD codes. They are reflected in the FY 2007 GROUPER, version 24.0 and are effective for discharges occurring on or after October 1, 2006. Table 8 below lists the FY 2007 new ICD diagnosis codes that impact the comorbidity adjustments under the IPF PPS, Table 9 lists the revised ICD codes, and Table 10 lists the invalid ICD codes no longer applicable for the comorbidity adjustment. Table 11 lists all of the currently valid ICD codes applicable for the IPF PPS comorbidity adjustments.
Table 8 -- FY 2007 New ICD Codes Applicable for the
Comorbidity Adjustments

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
<th>DRG</th>
<th>Comorbidity Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>052.2</td>
<td>Postvaricella myelitis</td>
<td>561</td>
<td>Infectious Diseases</td>
</tr>
<tr>
<td>053.14</td>
<td>Herpes zoster myelitis</td>
<td>561</td>
<td>Infectious Diseases</td>
</tr>
<tr>
<td>238.71</td>
<td>Essential thrombocythenia</td>
<td>398 – 399</td>
<td>Oncology Treatment</td>
</tr>
<tr>
<td>238.72</td>
<td>Low grade myelodysplastic syndrome lesions</td>
<td>395 – 396</td>
<td>Oncology Treatment</td>
</tr>
<tr>
<td>238.73</td>
<td>High grade myelodysplastic syndrome lesions</td>
<td>395 – 396</td>
<td>Oncology Treatment</td>
</tr>
<tr>
<td>238.74</td>
<td>Myelodysplastic syndrome with 5q deletion</td>
<td>395 – 396</td>
<td>Oncology Treatment</td>
</tr>
<tr>
<td>238.75</td>
<td>Myelodysplastic syndrome, unspecified</td>
<td>395 – 396</td>
<td>Oncology Treatment</td>
</tr>
<tr>
<td>238.76</td>
<td>Myelofibrosis with myeloid metaplasia</td>
<td>401 – 404, 539 – 540</td>
<td>Oncology Treatment</td>
</tr>
<tr>
<td>238.79</td>
<td>Other lymphatic and hematopoietic tissues</td>
<td>401 – 404, 539 – 540</td>
<td>Oncology Treatment</td>
</tr>
</tbody>
</table>

Table 9 below, which lists the FY 2007 revised ICD codes, does not reflect all of the currently valid ICD codes applicable for the IPF PPS comorbidity adjustments.
### TABLE 9--FY 2007 Revised ICD Codes

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
<th>DRG</th>
<th>Comorbidity Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>403.01</td>
<td>Hypertensive chronic kidney disease, malignant, with chronic kidney disease stage V or end stage renal disease</td>
<td>315 – 316</td>
<td>Renal Failure, Chronic</td>
</tr>
<tr>
<td>403.11</td>
<td>Hypertensive chronic kidney disease, benign, with chronic kidney disease stage V or end stage renal disease</td>
<td>315 – 316</td>
<td>Renal Failure, Chronic</td>
</tr>
<tr>
<td>403.91</td>
<td>Hypertensive chronic kidney disease, unspecified, with chronic kidney disease stage V or end stage renal disease</td>
<td>315 – 316</td>
<td>Renal Failure, Chronic</td>
</tr>
<tr>
<td>404.02</td>
<td>Hypertensive heart and chronic kidney disease, malignant, without heart failure and with chronic kidney disease stage V or end stage renal disease</td>
<td>315 – 316</td>
<td>Renal Failure, Chronic</td>
</tr>
<tr>
<td>404.03</td>
<td>Hypertensive heart and chronic kidney disease, malignant, with heart failure and with chronic kidney disease stage V or end stage renal disease</td>
<td>121, 124, 127, 535, 547, 549, 551, 553, 555, 557</td>
<td>Cardiac Conditions</td>
</tr>
<tr>
<td>404.12</td>
<td>Hypertensive heart and chronic kidney disease, benign, without heart failure and with chronic kidney disease stage V or end stage renal disease</td>
<td>315 – 316</td>
<td>Renal Failure, Chronic</td>
</tr>
<tr>
<td>404.13</td>
<td>Hypertensive heart and chronic kidney disease, benign, with heart failure and chronic kidney disease stage V or end stage renal disease</td>
<td>121, 124, 127, 535, 547, 549, 551, 553, 555, 557</td>
<td>Renal Failure, Chronic</td>
</tr>
<tr>
<td>404.92</td>
<td>Hypertensive heart and chronic kidney disease, unspecified, without heart failure and with chronic kidney disease stage V or end stage renal disease</td>
<td>315 – 316</td>
<td>Renal Failure, Chronic</td>
</tr>
<tr>
<td>404.93</td>
<td>Hypertensive heart and chronic kidney disease, unspecified, with heart failure and chronic kidney disease stage V or end stage renal disease</td>
<td>121, 124, 127, 535, 547, 549, 551, 553, 555, 557</td>
<td>Renal Failure, Chronic</td>
</tr>
</tbody>
</table>

In Table 10 below, we list the FY 2007 invalid ICD diagnosis code 238.7.
TABLE 10.—FY 2007 INVALID ICD CODES NO LONGER APPLICABLE FOR THE COMORBIDITY ADJUSTMENTS

<table>
<thead>
<tr>
<th>Diagnosis code</th>
<th>Description</th>
<th>DR</th>
<th>Comorbidity category</th>
</tr>
</thead>
<tbody>
<tr>
<td>238.7 ..........</td>
<td>Other lymphatic and hematopoietic tissues .................</td>
<td>413–414</td>
<td>Oncology Treatment.</td>
</tr>
</tbody>
</table>

The seventeen comorbidity categories for which we are providing an adjustment, their respective codes, including the new FY 2007 ICD codes, and their respective adjustment factors, are listed below in Table 11.

TABLE 11--RY 2008 Diagnosis Codes and Adjustment Factors for Comorbidity Categories

<table>
<thead>
<tr>
<th>Description of Comorbidity</th>
<th>ICD-9CM Code</th>
<th>Adjustment Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities</td>
<td>317, 3180, 3181, 3182, and 319</td>
<td>1.04</td>
</tr>
<tr>
<td>Coagulation Factor Deficits</td>
<td>2860 through 2864</td>
<td>1.13</td>
</tr>
<tr>
<td>Tracheostomy</td>
<td>51900 – through 51909 and V440</td>
<td>1.06</td>
</tr>
<tr>
<td>Renal Failure, Acute</td>
<td>5845 through 5849, 63630, 63631, 63632, 63730, 63731, 63732, 6383, 6393, 66932, 66934, 9585</td>
<td>1.11</td>
</tr>
<tr>
<td>Renal Failure, Chronic</td>
<td>40301, 40311, 40391, 40402, 40412, 40413, 40492, 40493, 5853, 5854, 5855, 5856, 5859, 586, V451, V560, V561, and V562</td>
<td>1.11</td>
</tr>
<tr>
<td>Oncology Treatment</td>
<td>1400 through 2399 with a radiation therapy code 92.21–92.29 or chemotherapy code 99.25</td>
<td>1.07</td>
</tr>
<tr>
<td>Uncontrolled Diabetes-Mellitus with or without complications</td>
<td>25002, 25003, 25012, 25013, 25022, 25023, 25032, 25033, 25042, 25043, 25052, 25053, 25062, 25063, 25072, 25073, 25082, 25083, 25092, and 25093</td>
<td>1.05</td>
</tr>
<tr>
<td>Severe Protein Calorie Malnutrition</td>
<td>260 through 262</td>
<td>1.13</td>
</tr>
<tr>
<td>Eating and Conduct Disorders</td>
<td>3071, 30750, 31203, 31233, and 31234</td>
<td>1.12</td>
</tr>
<tr>
<td>Infectious Disease</td>
<td>01000 through 04110, 042, 04500 through 05319, 05440 through 05449, 0550 through 0770, 0782 through 07889, and 07950 through 07959</td>
<td>1.07</td>
</tr>
<tr>
<td>Drug and/or Alcohol Induced Mental Disorders</td>
<td>2910, 2920, 29212, 2922, 30300, and 30400</td>
<td>1.03</td>
</tr>
<tr>
<td>Cardiac Conditions</td>
<td>3910, 3911, 3912, 40201, 40403, 4160, 4210, 4211, and 4219</td>
<td>1.11</td>
</tr>
<tr>
<td>Gangrene</td>
<td>44024 and 7854</td>
<td>1.10</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>49121, 4941, 5100, 51883, 51884, V4611 and V4612, V4613 and V4614</td>
<td>1.12</td>
</tr>
<tr>
<td>Artificial Openings - Digestive and Urinary</td>
<td>56960 through 56969, 9975, and V441 through V446</td>
<td>1.08</td>
</tr>
<tr>
<td>Severe Musculoskeletal and Connective Tissue Diseases</td>
<td>6960, 7100, 73000 through 73009, 73010 through 73019, and 73020 through 73029</td>
<td>1.09</td>
</tr>
<tr>
<td>Poisoning</td>
<td>96500 through 96509, 9654, 9670 through 9699, 9770, 9800 through 9809, 9830 through 9839, 986, 9890 through 9897</td>
<td>1.11</td>
</tr>
</tbody>
</table>

3. Patient Age Adjustments

As explained in the November 2004 IPF PPS final rule, we analyzed the impact of age on per diem cost by examining the age variable (that is, the range of ages) for payment adjustments.

In general, we found that the cost per day increases with increasing age. The older age groups are more costly than the under 45 age group, the differences in per diem cost increase for each successive age group, and the differences are statistically significant.

We do not plan to update the regression analysis until we analyze IPF PPS data. For RY 2008, we are continuing to use the patient age adjustments currently in effect and as shown in Table 12 below.

TABLE 12.—AGE GROUPINGS AND ADJUSTMENT FACTORS

<table>
<thead>
<tr>
<th>Age</th>
<th>Adjustment factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 45</td>
<td>1.00</td>
</tr>
<tr>
<td>45 and under 50</td>
<td>1.01</td>
</tr>
<tr>
<td>50 and under 55</td>
<td>1.02</td>
</tr>
<tr>
<td>55 and under 60</td>
<td>1.04</td>
</tr>
<tr>
<td>60 and under 65</td>
<td>1.07</td>
</tr>
<tr>
<td>65 and under 70</td>
<td>1.10</td>
</tr>
</tbody>
</table>
TABLE 12.—AGE GROUPINGS AND ADJUSTMENT FACTORS—Continued

<table>
<thead>
<tr>
<th>Age</th>
<th>Adjustment factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>70 and under 75</td>
<td>1.13</td>
</tr>
<tr>
<td>75 and under 80</td>
<td>1.15</td>
</tr>
<tr>
<td>80 and over</td>
<td>1.17</td>
</tr>
</tbody>
</table>

4. Variable Per Diem Adjustments

We explained in the November 2004 IPF PPS final rule that a regression analysis indicated that per diem cost declines as the LOS increases (69 FR 66946). The variable per diem adjustments to the Federal per diem base rate account for ancillary and administrative costs that occur disproportionately in the first days after admission to an IPF.

We used a regression analysis to estimate the average differences in per diem cost among stays of different lengths. As a result of this analysis, we established variable per diem adjustments that begin on day 1 and decline gradually until day 21 of a patient’s stay. For day 22 and thereafter, the variable per diem adjustment remains the same each day for the remainder of the stay. However, the adjustment applied to day 1 depends upon whether the IPF has a qualifying ED. If an IPF has a qualifying ED, it receives a 1.31 adjustment factor for day 1 of each patient stay. If an IPF does not have a qualifying ED, it receives a 1.19 adjustment factor for day 1 of the stay. The ED adjustment is explained in more detail in section IV.C.5 of this notice.

As previously stated, we do not plan to make changes to the regression analysis until we analyze IPF PPS data. Therefore, for RY 2008, we are continuing to use the variable per diem adjustment factors currently in effect as shown in Table 13 below.

A complete discussion of the variable per diem adjustments appears in the November 2004 IPF PPS final rule (69 FR 66946).

BILLING CODE 4120–01–P
C. Facility-Level Adjustments

The IPF PPS includes facility-level adjustments for the wage index, IPFs located in rural areas, teaching IPFs, cost of living adjustments for IPFs located in Alaska and Hawaii, and IPFs with a qualifying ED.

1. Wage Index Adjustment

As discussed in the May 2006 IPF PPS final rule, in providing an adjustment for area wage levels, the labor-related portion of an IPF’s Federal prospective payment is adjusted using an appropriate wage index. An IPF’s area wage index value is determined based on the actual location of the IPF in an urban or rural area as defined in § 412.64(b)(1)(ii)(A) through (C).

Since the inception of a PPS for IPFs, we have used hospital wage data in developing a wage index to be applied to IPFs. We are continuing that practice for RY 2008. We apply the wage index adjustment to the labor-related portion of the Federal rate, which is 75.788 percent. This percentage reflects the labor-related relative importance of the RPL market basket for RY 2008. The IPF PPS uses the pre-floor, pre-reclassified hospital wage index. Changes to the

<table>
<thead>
<tr>
<th>Day-Of-Stay</th>
<th>Adjustment Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1- IPF Without a Qualified ED</td>
<td>1.19</td>
</tr>
<tr>
<td>Day 1- IPF With a Qualified ED</td>
<td>1.31</td>
</tr>
<tr>
<td>Day 2</td>
<td>1.12</td>
</tr>
<tr>
<td>Day 3</td>
<td>1.08</td>
</tr>
<tr>
<td>Day 4</td>
<td>1.05</td>
</tr>
<tr>
<td>Day 5</td>
<td>1.04</td>
</tr>
<tr>
<td>Day 6</td>
<td>1.02</td>
</tr>
<tr>
<td>Day 7</td>
<td>1.01</td>
</tr>
<tr>
<td>Day 8</td>
<td>1.01</td>
</tr>
<tr>
<td>Day 9</td>
<td>1.00</td>
</tr>
<tr>
<td>Day 10</td>
<td>1.00</td>
</tr>
<tr>
<td>Day 11</td>
<td>0.99</td>
</tr>
<tr>
<td>Day 12</td>
<td>0.99</td>
</tr>
<tr>
<td>Day 13</td>
<td>0.99</td>
</tr>
<tr>
<td>Day 14</td>
<td>0.99</td>
</tr>
<tr>
<td>Day 15</td>
<td>0.98</td>
</tr>
<tr>
<td>Day 16</td>
<td>0.97</td>
</tr>
<tr>
<td>Day 17</td>
<td>0.97</td>
</tr>
<tr>
<td>Day 18</td>
<td>0.96</td>
</tr>
<tr>
<td>Day 19</td>
<td>0.95</td>
</tr>
<tr>
<td>Day 20</td>
<td>0.95</td>
</tr>
<tr>
<td>Day 21</td>
<td>0.95</td>
</tr>
<tr>
<td>After Day 21</td>
<td>0.92</td>
</tr>
</tbody>
</table>
wage index are made in a budget neutral manner, so that updates do not increase expenditures.

For FY 2008, we are applying the most recent hospital wage index using the hospital wage data, and applying an adjustment in accordance with our budget neutrality policy. This policy requires us to estimate the total amount of IPF PPS payments in FY 2007 and divide that amount by the total estimated IPF PPS payments in FY 2008. The estimated payments are based on FY 2005 IPF claims, inflated to the appropriate FY. This quotient is the wage index budget neutrality factor, and it is applied in the update of the Federal per diem base rate for FY 2008. The wage index budget neutrality factor for FY 2008 is 1.0014.

The wage index applicable for FY 2008 appears in Table 1 and Table 2 in the Addendum of this notice. As explained in the May 2006 IPF PPS final rule for FY 2007 (71 FR 27061), the IPF PPS applies the hospital wage index without a hold-harmless policy, and without an out-commuting adjustment or out-migration adjustment because we feel these policies apply only to the IPPS.

In the May 2006 IPF PPS final rule for FY 2007 (71 FR 27061), we adopted the changes discussed in the Office of Management and Budget (OMB) Bulletin No. 03-04 (June 6, 2003), which announced revised definitions for Metropolitan Statistical Areas (MSAs), and the creation of Micropolitan Statistical Areas and Combined Statistical Areas. In adopting the OMB Core-Based Statistical Area (CBSA) geographic designations, since the IPF PPS is already in a transition period from TEFRA payments to PPS payments, we did not provide a separate transition for the wage index.

As was the case in FY 2007, for FY 2008, we will be using the full CBSA-based wage index values as presented in Tables 1 and 2 in the Addendum of this notice.

Finally, we continue to use the same methodology discussed in the IPF PPS proposed rule for FY 2007 (71 FR 3633) and finalized in the May 2006 IPF PPS final rule for FY 2007 (71 FR 27061) to address those geographic areas where there are no hospitals and, thus, no hospital wage index data on which to base the calculation of the FY 2008 IPF PPS wage index. For FY 2008, those areas consist of rural Massachusetts, rural Puerto Rico and urban CBSA (25980) Hinesville-Fort Stewart, GA. A complete discussion of the CBSA labor market definitions appears in the May 2006 IPF PPS final rule (71 FR 27061 through 27067).

2. Adjustment for Rural Location

In the November 2004 IPF PPS final rule, we provided a 17 percent payment adjustment for IPFs located in a rural area. This adjustment was based on the regression analysis which indicated that the per diem cost of rural facilities was 17 percent higher than that of urban facilities after accounting for the influence of the other variables included in the regression. As previously stated, we do not intend to update the regression analysis until we analyze the IPF PPS data. At that time, we can compare rural and urban IPFs to determine how much more costly rural facilities are on a per diem basis under the IPF PPS.

For FY 2008, we are applying a 17 percent payment adjustment for IPFs located in a rural area as defined at §412.64(b)(1)(ii)(C). A complete discussion of the adjustment for rural locations appears in the November 2004 IPF PPS final rule (69 FR 66954).

3. Teaching Adjustment

In the November 2004 IPF PPS final rule, we implemented regulations at §412.424(d)(1)(iii) to establish a facility-level adjustment for IPFs that are, or are part of, teaching institutions. The teaching status adjustment accounts for the higher indirect operating costs experienced by facilities that participate in graduate medical education (GME) programs. Payments are made based on the number of full-time equivalent interns and residents training in the IPF.

Medicare makes direct GME payments (for direct costs such as resident and teaching physician salaries, and other direct teaching costs) to all teaching hospitals including those paid under the IPPS, and those that were once paid under the TEFRA rate-of-increase limits but are now paid under other PPSs. These direct GME payments are made separately from payments for hospital operating costs and are not part of the PPSs. The direct GME payments do not address the higher indirect operating costs experienced by teaching hospitals.

For teaching hospitals paid under the TEFRA rate-of-increase limits, Medicare did not make separate medical education payments because payments to these hospitals were based on the hospitals’ reasonable costs. Since payments under TEFRA were based on hospitals’ reasonable costs, the higher indirect costs that might be associated with teaching programs would automatically have been factored into the TEFRA payments.

The results of the regression analysis of FY 2002 IPF data established the basis for the payment adjustments included in the November 2004 IPF PPS final rule. The results showed that the indirect teaching cost variable is significant in explaining the higher costs of IPFs that have teaching programs. We calculated the teaching adjustment based on the IPF’s “teaching variable,” which is one plus the ratio of the number of full-time equivalent (FTE) residents training in the IPF (subject to limitations described below) to the IPF’s average daily census (ADC).

In the regression analysis, the logarithm of the teaching variable had a coefficient value of 0.5150. We converted this cost effect to a teaching payment adjustment by treating the regression coefficient as an exponent and raising the teaching variable to a power equal to the coefficient value. We note that the coefficient value of 0.5150 was based on the regression analysis holding all other components of the payment system constant.

As with other adjustment factors derived through the regression analysis, we do not plan to rerun the regression analysis until we analyze IPF PPS data. Therefore, for FY 2008, we are retaining the coefficient value of 0.5150 for the teaching status adjustment to the Federal per diem base rate.

A complete discussion of how the teaching status adjustment was calculated appears in the November 2004 IPF PPS final rule (69 FR 66954 through 66957) and the May 2006 IPF PPS final rule (71 FR 27067 through 27070).

4. Cost of Living Adjustment for IPFs Located in Alaska and Hawaii

The IPF PPS includes a payment adjustment for IPFs located in Alaska and Hawaii based upon the county in which the IPF is located. As we explained in the November 2004 IPF PPS final rule, the FY 2002 data demonstrated that IPFs in Alaska and Hawaii had per diem costs that were disproportionately higher than other IPFs. Other Medicare PPSs (for example, the IPPS and IRF PPSs) have adopted a cost of living adjustment (COLA) to account for the cost differential of care furnished in Alaska and Hawaii.

We analyzed the effect of applying a COLA to payments for IPFs located in Alaska and Hawaii. The results of our analysis demonstrated that a COLA for IPFs located in Alaska and Hawaii would improve payment equity for these facilities. As a result of this analysis, we provided a COLA in the November 2004 IPF PPS final rule.

In general, the COLA increases for the higher costs in the IPF and eliminates the projected loss that IPFs in Alaska
and Hawaii would experience absent the COLA. A COLA factor for IPFs located in Alaska and Hawaii is made by multiplying the non-labor share of the Federal per diem base rate by the applicable COLA factor based on the COLA area in which the IPF is located.

As previously stated, we will update the COLA factors if applicable, as updated by OPM. On August 2, 2006, the U.S. Office of Personnel Management (OPM) issued a final rule to change COLA rates effective September 1, 2006.

The COLA factors are published on the OPM Web site at (http://www.opm.gov/oca/cola/rates.asp). We note that the COLA areas for Alaska are not defined by county as are the COLA areas for Hawaii. In 5 CFR § 591.207, the OPM established the following COLA areas:

- (a) City of Anchorage, and 80-kilometer (50-mile) radius by road, as measured from the Federal courthouse;
- (b) City of Fairbanks, and 80-kilometer (50-mile) radius by road, as measured from the Federal courthouse;
- (c) City of Juneau, and 80-kilometer (50-mile) radius by road, as measured from the Federal courthouse;
- (d) Rest of the State of Alaska.

In the November 2004 and May 2006 IPF PPS final rules, we showed only one COLA for Alaska because all four areas were the same amount (1.25). Effective September 1, 2006, the OPM updated the COLA amounts and there are now two different amounts for the Alaska COLA areas (1.24 and 1.25).

For RY 2008, IPFs located in Alaska and Hawaii will receive the updated COLA factors based on the COLA area in which the IPF is located and as shown in Table 14 below.

### Table 14.—COLA FACTORS FOR ALASKA AND HAWAII IPFS

<table>
<thead>
<tr>
<th>Location</th>
<th>COLA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anchorage</td>
<td>1.24</td>
</tr>
<tr>
<td>Fairbanks</td>
<td>1.24</td>
</tr>
<tr>
<td>Juneau</td>
<td>1.24</td>
</tr>
<tr>
<td>Rest of Alaska</td>
<td>1.25</td>
</tr>
<tr>
<td>Honolulu County</td>
<td>1.25</td>
</tr>
<tr>
<td>Hawaii County</td>
<td>1.17</td>
</tr>
<tr>
<td>Kauai County</td>
<td>1.25</td>
</tr>
<tr>
<td>Maui County</td>
<td>1.25</td>
</tr>
<tr>
<td>Kalawao County</td>
<td>1.25</td>
</tr>
</tbody>
</table>

5. Adjustment for IPFs With a Qualifying Emergency Department (ED)

Currently, the IPF PPS includes a facility-level adjustment for IPFs with qualifying EDs. We provide an adjustment to the standardized Federal per diem base rate to account for the costs associated with maintaining a full-service ED. The adjustment is intended to account for ED costs allocated to the hospital’s distinct part psychiatric unit for preadmission services otherwise payable under the Medicare Outpatient Prospective Payment System (OPPS) furnished to a beneficiary during the day immediately preceding the date of admission to the IPF (see § 413.40(c)) and the overhead cost of maintaining the ED. This payment is a facility-level adjustment that applies to all IPF admissions (with the one exception as described below), regardless of whether a particular patient receives preadmission services in the hospital’s ED.

The ED adjustment is incorporated into the variable per diem adjustment for the first day of each stay for IPFs with a qualifying ED. That is, IPFs with a qualifying ED receive an adjustment factor of 1.31 as the variable per diem adjustment factor for day 1 of each stay. If an IPF does not have a qualifying ED, it receives an adjustment factor of 1.19 as the variable per diem adjustment for day 1 of each patient stay.

The ED adjustment is made on every qualifying claim except as described below. As specified in § 412.424(d)(1)(v)(B), the ED adjustment is not made where a patient is discharged from an acute care hospital or CAH and admitted to the same hospital’s or CAH’s psychiatric unit. An ED adjustment is not made in this case because the costs associated with ED services are reflected in the DRG payment to the acute care hospital or through the reasonable cost payment made to the CAH. If we provided the ED adjustment in these cases, the hospital would be paid twice for the overhead costs of the ED (69 FR 66960).

Therefore, when patients are discharged from an acute care hospital or CAH and admitted to the same hospital’s or CAH’s psychiatric unit, the IPF receives the 1.19 adjustment factor as the variable per diem adjustment for the first day of the patient’s stay in the IPF. As previously stated, we do not intend to conduct a new regression analysis for this IPF PPS update. Rather, we plan to wait until we analyze IPF PPS data.

For RY 2008, we are retaining the 1.31 adjustment factor for IPFs with qualifying EDs.

A complete discussion of the steps involved in the calculation of the ED adjustment factor appears in the November 2004 IPF PPS final rule (69 FR 66959 through 67000) and the May 2006 IPF PPS final rule (71 FR 27070 through 27072).

### D. Other Payment Adjustments and Policies

For RY 2008, the IPF PPS includes the following payment adjustments: an outlier adjustment to promote access to IPF care for those patients who require expensive care and to limit the financial risk of IPFs treating unusually costly patients, and a stop-loss provision, applicable during the transition period, to reduce financial risk to IPFs projected to experience substantial reductions in Medicare payments under the IPF PPS.

1. **Outlier Payments**

In the November 2004 IPF PPS final rule, we implemented regulations at § 412.424(d)(3)(ii) to provide a per-case payment for IPF stays that are extraordinarily costly. Providing additional payments for outlier cases to IPFs that are beyond the IPF’s control strongly improves the accuracy of the IPF PPS in determining resource costs at the patient and facility level because facilities receive additional compensation over and above the adjusted Federal prospective payment amount for uniquely high-cost cases. These additional payments reduce the financial losses that would otherwise be caused by treating patients who require more costly care and, therefore, reduce the incentives to under-serve these patients.

We make outlier payments for discharges in which an IPF’s estimated total cost for a case exceeds a fixed dollar loss threshold amount (multiplied by the IPF’s facility-level adjustments) plus the Federal per diem payment amount for the case.

In instances when the case qualifies for an outlier payment, we pay 80 percent of the difference between the estimated cost for the case and the adjusted threshold amount for days 1 through 9 of the stay (consistent with the median LOS for IPFs in FY 2002), and 60 percent of the difference for day 10 and thereafter. We established the 80 percent and 60 percent loss sharing ratios because we were concerned that a single ratio established at 80 percent (like other Medicare PPSs) might provide an incentive under the IPF per diem payment system to increase LOS in order to receive additional payments. After establishing the loss sharing ratios, we determined the current fixed dollar loss threshold amount of $6,200 through payment simulations designed to compute a dollar loss beyond which payments are estimated to meet the 2 percent outlier spending target.
a. Update to the Outlier Fixed Dollar Loss Threshold Amount

In accordance with the update methodology described in §412.428(d), we are updating the fixed dollar loss threshold amount used under the IPF PPS outlier policy. Based on the regression analysis and payment simulations used to develop the IPPS, we established a 2 percent outlier policy which strikes an appropriate balance between protecting IPFs from extraordinarily costly cases while ensuring the adequacy of the Federal per diem base rate for all other cases that are not outlier cases.

We believe it is necessary to update the fixed dollar loss threshold amount because analysis of the latest available data (that is, FY 2005 IPF claims) and rate increases indicates adjusting the fixed dollar loss amount is necessary in order to maintain an outlier percentage that equals 2 percent of total estimated IPF PPS payments.

In the May 2006 IPF PPS Final Rule (71 FR 27072), we describe the process by which we calculate the outlier fixed dollar loss threshold amount. We will continue to use this process for FY 2008. We begin by simulating aggregate payments with and without an outlier policy, and applying an iterative process to a fixed dollar loss amount that will result in outlier payments being equal to 2 percent of total estimated payments under the simulation.

Based on this process, for FY 2008, the IPF PPS will use $6,488 as the fixed dollar loss threshold amount in the outlier calculation in order to maintain the 2 percent outlier policy.

b. Statistical Accuracy of Cost-to-Charge Ratios

As previously stated, under the IPF PPS, an outlier payment is made if an IPF’s cost for a stay exceeds a fixed dollar loss threshold amount. In order to establish an IPF’s cost for a particular case, we multiply the IPF’s reported charges on the discharge bill by its overall cost to charge ratio (CCR). This approach to determining an IPF’s cost is consistent with the approach used under the IPPS and other PPSs. In FY 2004, we implemented changes to the IPPS outlier policy used to determine CCRs for acute care hospitals because we became aware that payment vulnerabilities resulted in inappropriate outlier payments. Under the IPPS, we established a statistical measure of accuracy for CCRs in order to ensure that aberrant CCR data did not result in inappropriate outlier payments.

As we indicated in the November 2004 IPF PPS final rule, because we believe that the IPF outlier policy is susceptible to the same payment vulnerabilities as the IPPS, we adopted an approach to ensure the statistical accuracy of CCRs under the IPF PPS (69 FR 66961). Therefore, we adopted the following procedure in the November 2004 IPF PPS final rule:

- We calculated two national ceilings, one for IPFs located in rural areas and one for IPFs located in urban areas. We computed the ceilings by first calculating the national average and the standard deviation of the CCR for both urban and rural IPFs.
- To determine the urban and rural ceilings, we multiplied each of the standard deviations by 3 and added the result to the appropriate national CCR average (either rural or urban). The upper threshold CCR for IPFs in FY 2008 is 1.7255 for rural IPFs, and 1.7947 for urban IPFs, based on CBSA-based geographic designations. If an IPF’s CCR is above the applicable ceiling, the ratio is considered statistically inaccurate and we assign the appropriate national (either rural or urban) median CCR to the IPF.
- We are applying the national CCRs to the following situations:
  - New IPFs that have not yet submitted their first Medicare cost report.
  - IPFs whose operating or capital CCR is in excess of 3 standard deviations above the corresponding national geometric mean (that is, above the ceiling).
  - Other IPFs for whom the Medicare contractor obtains inaccurate or incomplete data with which to calculate either an operating or capital CCR or both.

For new IPFs, we are using these national CCRs until the facility’s actual CCR can be computed using the first tentatively settled or final settled cost report, which will then be used for the subsequent cost report period.

We are not making any changes to the procedures for ensuring the statistical accuracy of CCRs in FY 2008. However, we are updating the national urban and rural CCRs (ceilings and medians) for IPFs for FY 2008 based on the CCRs entered in the latest available IPF PPS Provider Specific File.

The national CCRs for FY 2008 are 0.71 for rural IPFs and 0.55 for urban IPFs and will be used in each of the three situations listed above. These calculations are based on the IPF’s location (either urban or rural) using the CBSA-based geographic designations.

A complete discussion regarding the methodology described in §412.428(d), the update to the CCR fixed dollar loss threshold amount, and the methodology used to establish an IPF’s cost for a particular stay can be found in the November 2004 IPF PPS final rule (69 FR 66961 through 66964).

2. Stop-Loss Provision

In the November 2004 IPF PPS final rule, we implemented a stop-loss policy that reduces financial risk to IPFs expected to experience substantial reductions in Medicare payments during the period of transition to the IPF PPS. This stop-loss policy guarantees that each facility receives total IPF PPS payments that are no less than 70 percent of their TEFRA payments, had the IPF PPS not been implemented.

This policy is applied to the IPF PPS portion of Medicare payments during the 3-year transition. During the first year, for transitioning IPFs, three-quarters of the payment was based on TEFRA and one-quarter on the IPF PPS payment amount. In the second year, one-half of the payment is based on TEFRA and one-half on the IPF PPS payment amount. In the third year, one-quarter of the payment is based on TEFRA and three-quarters on the IPF PPS. For cost report periods beginning on or after January 1, 2008, payments will be based 100 percent on the IPF PPS.

The combined effects of the transition and the stop-loss policies ensure that the total estimated IPF PPS payments are no less than 92.5 percent in the first year, 85 percent in the second year, and 77.5 percent in the third year. Under the 70 percent policy, in the third year, 25 percent of an IPF’s payment is TEFRA payments, and 75 percent is IPF PPS payments, which are guaranteed to be at least 70 percent of the TEFRA payments. The resulting 77.5 percent of TEFRA payments is the sum of 25 percent and 75 percent times 70 percent (which equals 52.5 percent).

In the implementation year, the 70 percent of TEFRA payment stop-loss policy required a reduction in the standardized Federal per diem and ECT base rates of 0.39 percent in order to make the stop-loss payments budget neutral.

For the FY 2008, we are not making any changes to the stop-loss policy. We will continue to monitor expenditures under this policy to evaluate its effectiveness in targeting stop-loss payments to IPFs facing the greatest financial risk.

V. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the Federal Register to provide a period for public comment before the provisions of a rule take effect. We can waive this procedure, however, if we find good cause that a notice-and-comment procedure is impracticable, unnecessary, or contrary to the public
interest and we incorporate a statement of finding and its reasons in the notice. We find it is unnecessary to undertake notice and comment rulemaking for the update in this notice because the update does not make any substantive changes in policy, but merely reflects the application of previously established methodologies. Therefore, under 5 U.S.C. § 553(b)(3)(B), for good cause, we waive notice and comment procedures.

VI. Collection of Information Requirement
This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

VII. Regulatory Impact Analysis
A. Overall Impact
We have examined the impacts of this notice as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (UMRA) (Pub. L. 104–4), and Executive Order 13132.

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). For purposes of Title 5, United States Code, section 804(2), we treat this notice as a major rule because we estimate that the total impact of these changes would be an increase in payments of approximately $130 million.

The updates to the IPF labor-related share and wage indices are made in a budget neutral manner and thus have no effect on estimated costs to the Medicare program. Therefore, the estimated increased cost to the Medicare program is due to the update to the payment rates, which results in an increase of approximately $130 million in overall IPF payments from RY 2007 to RY 2008. The transition blend has a minimal impact on overall IPF payments in RY 2008. The distribution of these impacts is summarized in Table 15. The effect of the updates described in this notice result in an overall $130 million increase in payments from RY 2007 to RY 2008.

The RFA requires agencies to analyze options for regulatory relief of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most IPFs and most other providers and suppliers are considered small entities, either by nonprofit status or by having revenues of $6.5 million to $31.5 million in any 1 year. (For details, see the Small Business Administration’s Interim final rule that set forth size standards at 70 FR 72577, December 6, 2005.) Because we lack data on individual hospital receipts, we cannot determine the number of small proprietary IPFs or the proportion of IPFs’ revenue that is derived from Medicare payments. Therefore, we assume that all IPFs are considered small entities. As shown in Table 15, we estimate that the net revenue impact of this notice on all IPFs is to increase payments by about 3.1 percent. Thus, we anticipate that this notice may have a significant impact on a substantial number of small entities. However, the estimated impact of this notice is a net increase in revenues across all categories of IPFs, so we believe that this notice would not impose a significant burden on small entities. Medicare contractors are not considered to be small entities. Individuals and States are not included in the definition of small entity.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we previously defined a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA). However, under the new labor market definitions, we no longer employ NECMAs to define urban areas in New England. Therefore, for purposes of this analysis, we now define a small rural hospital as a hospital with fewer than 100 beds that is located outside of an MSA.

We have determined that this notice will have a substantial impact on hospitals located as defined above in rural areas. As discussed earlier in this preamble, we will continue to provide a payment adjustment of 17 percent for IPFs located in rural areas. In addition, we have established a 3-year transition to the new system to allow IPFs an opportunity to adjust to the new system. Therefore, the impacts shown in Table 15 below reflect the adjustments that are designed to minimize or eliminate any potentially significant negative impact that the IPF PPS may otherwise have on small rural IPFs.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any final rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately $120 million. This notice will not mandate any requirements for State, local, or tribal governments, nor would it affect private sector costs.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a final rule that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. We have reviewed this notice under the criteria set forth in Executive Order 13132 and have determined that the notice will not have any substantial impact on the rights, roles, and responsibilities of State, local, or tribal governments.

B. Anticipated Effects of the Notice
We discuss below the historical background of the IPF PPS and the impact of this notice on the Federal Medicare budget and on IPFs.

1. Budgetary Impact
As discussed in the November 2004 and May 2006 IPF PPS final rules, we applied a budget neutrality factor to the Federal per diem and ECT base rates to ensure that total estimated payments under the IPF PPS in the implementation period would equal the amount that would have been paid if the IPF PPS had not been implemented. The budget neutrality factor includes the following components: Outlier adjustment, stop-loss adjustment, and the behavioral offset. We do not plan to change any of these adjustment factors or projections until we analyze IPF PPS data. In accordance with § 412.424(c)(3)(ii), we will evaluate the accuracy of the budget neutrality adjustment within the first 5 years after implementation of the payment system. We may make a one-time prospective adjustment to the Federal per diem and ECT base rates to account for differences...
between the historical data on cost-based TEFRA payments (the basis of the budget neutrality adjustment) and estimates of TEFRA payments based on actual data from the first year of the IPF PPS. As part of that process, we will reassess the accuracy of all of the factors impacting budget neutrality.

In addition, as discussed in section IV.C.1. of this notice, we are adopting the wage index and labor market share in a budget neutral manner by applying a wage index budget neutrality factor to the Federal per diem and ECT base rates. Thus, the budgetary impact to the Medicare program by the update of the IPF PPS will be due to the market basket updates (see section III.B. of this notice) and the planned update of the payment blend discussed below.

2. Impacts on Providers

To understand the impact of the changes to the IPF PPS discussed in this notice on providers, it is necessary to compare estimated payments under the IPF PPS rates and factors for RY 2008 to estimated payments under the IPF PPS rates and factors for RY 2007. The estimated payments for RY 2007 are a blend of: 50 percent of the facility-specific TEFRA payment and 50 percent of the IPF PPS payment with stop-loss payment. The estimated payments for the RY 2008 IPF PPS are a blend of: 25 percent of the facility-specific TEFRA payment and 75 percent of the IPF PPS payment with stop-loss payment. We determined the percent change of estimated RY 2008 IPF PPS payments to estimated RY 2007 IPF PPS payments for each category of IPFs. In addition, for each category of IPFs, we have included the estimated percent change in payments resulting from the wage index changes for the RY 2008 IPF PPS, the market basket update to IPF PPS payments, and the transition blend for the RY 2008 IPF PPS payment and the facility-specific TEFRA payment.

To illustrate the impacts of the final RY 2008 changes, our analysis begins with a RY 2007 baseline simulation model based on FY 2005 IPF payments inflated to the midpoint of RY 2007 using Global Insight’s most recent forecast of the market basket update (see section III.B. of this notice); the estimated outlier payments in RY 2007; the estimated stop-loss payments in RY 2007; the CBSA designations for IPFs based on OMB’s MSA definitions after June 2003; the FY 2006 pre-floor, pre-reclassified hospital wage index; the RY 2007 labor-market share; and the RY 2007 percentage amount of the rural adjustment. During the simulation, the outlier payment is maintained at the target of 2 percent of total PPS payments.

Each of the following changes is added incrementally to this baseline model in order for us to isolate the effects of each change:

- The FY 2007 pre-floor, pre-reclassified hospital wage index and RY 2008 final labor-related share.
- A blended market basket update of 3.2 percent resulting in an update to the hospital-specific TEFRA payment amount and an update to the IPF PPS base rates.
- The transition to 75 percent IPF PPS payment and 25 percent facility-specific TEFRA payment.
- Our final comparison illustrates the percent change in payments from RY 2007 (that is, July 1, 2006 to June 30, 2007) to RY 2008 (that is, July 1, 2007 to June 30, 2008).

### TABLE 15--Projected Impacts

<table>
<thead>
<tr>
<th>Facility By Type (1)</th>
<th>Number of Facilities (2)</th>
<th>CBSA Wage Index and Labor Share (3)</th>
<th>Market Basket (4)</th>
<th>Transition Blend (5)</th>
<th>Total (6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Facilities</td>
<td>1,712</td>
<td>0.0%</td>
<td>3.2%</td>
<td>-0.1%</td>
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</tr>
<tr>
<td>Urban</td>
<td>1,345</td>
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<tr>
<td>Rural</td>
<td>367</td>
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<td>Urban unit</td>
<td>987</td>
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<td>Rural unit</td>
<td>317</td>
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<td>Freestanding IPFs</td>
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<td>Facility By Type (1)</td>
<td>Number of Facilities (2)</td>
<td>CBSA Wage Index and Labor Share (3)</td>
<td>Market Basket (4)</td>
<td>Transition Blend (5)</td>
<td>Total (6)</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>--------------------------</td>
<td>--------------------------------------</td>
<td>-------------------</td>
<td>----------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Government</td>
<td>142</td>
<td>0.1%</td>
<td>3.2%</td>
<td>8.7%</td>
<td>12.4%</td>
</tr>
<tr>
<td>Non-Profit</td>
<td>79</td>
<td>-0.1%</td>
<td>3.2%</td>
<td>1.2%</td>
<td>4.4%</td>
</tr>
<tr>
<td>For-Profit</td>
<td>137</td>
<td>0.1%</td>
<td>3.2%</td>
<td>6.4%</td>
<td>9.9%</td>
</tr>
<tr>
<td>Rural Psychiatric Hospitals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government</td>
<td>39</td>
<td>0.1%</td>
<td>3.2%</td>
<td>8.8%</td>
<td>12.4%</td>
</tr>
<tr>
<td>Non-Profit</td>
<td>5</td>
<td>-0.3%</td>
<td>3.2%</td>
<td>-3.0%</td>
<td>-0.1%</td>
</tr>
<tr>
<td>For-Profit</td>
<td>6</td>
<td>0.3%</td>
<td>3.2%</td>
<td>5.9%</td>
<td>9.6%</td>
</tr>
</tbody>
</table>

| By Teaching Status:         |                          |                                      |                   |                      |           |
| Non-teaching                | 1,450                    | 0.0%                                 | 3.2%              | -0.1%                | 3.1%      |
| Less than 10% interns and   | 155                      | 0.0%                                 | 3.2%              | 0.8%                 | 4.0%      |
| residents to beds          |                          |                                      |                   |                      |           |
| 10% to 30% interns and     | 72                       | 0.0%                                 | 3.2%              | -1.2%                | 2.0%      |
| residents to beds          |                          |                                      |                   |                      |           |
| More than 30% interns and   | 35                       | 0.1%                                 | 3.2%              | -1.9%                | 1.3%      |
| residents to beds          |                          |                                      |                   |                      |           |

| By Region:                  |                          |                                      |                   |                      |           |
| New England                 | 128                      | -0.2%                                | 3.2%              | -1.8%                | 1.2%      |
| Mid-Atlantic                | 289                      | 0.0%                                 | 3.2%              | 2.7%                 | 6.0%      |
| South Atlantic              | 221                      | -0.1%                                | 3.2%              | 0.3%                 | 3.4%      |
| East North Central          | 301                      | 0.1%                                 | 3.2%              | -1.6%                | 1.7%      |
| East South Central          | 155                      | 0.0%                                 | 3.2%              | -0.3%                | 2.8%      |
| West North Central          | 167                      | 0.0%                                 | 3.2%              | -1.5%                | 1.7%      |
| West South Central          | 211                      | -0.2%                                | 3.2%              | -1.1%                | 1.8%      |
| Mountain                    | 84                       | 0.5%                                 | 3.2%              | 1.1%                 | 4.9%      |
| Pacific                     | 148                      | 0.1%                                 | 3.2%              | -0.4%                | 3.0%      |

| By Bed Size:                |                          |                                      |                   |                      |           |
| Psychiatric Hospitals       |                          |                                      |                   |                      |           |
| Under 12 beds               | 23                       | 0.1%                                 | 3.2%              | -2.0%                | 1.3%      |
| 12 to 25 beds               | 46                       | 0.2%                                 | 3.2%              | -0.2%                | 3.2%      |
| 25 to 50 beds               | 92                       | -0.1%                                | 3.2%              | 3.7%                 | 6.9%      |
| 50 to 75 beds               | 77                       | 0.2%                                 | 3.2%              | 6.0%                 | 9.6%      |
| Over 75 beds                | 170                      | 0.0%                                 | 3.2%              | 7.8%                 | 11.3%     |
| Psychiatric Units           |                          |                                      |                   |                      |           |
| Under 12 beds               | 532                      | 0.0%                                 | 3.2%              | -4.4%                | -1.3%     |
| 12 to 25 beds               | 451                      | 0.0%                                 | 3.2%              | -2.5%                | 0.6%      |
| 25 to 50 beds               | 223                      | -0.1%                                | 3.2%              | -1.1%                | 2.0%      |
| 50 to 75 beds               | 56                       | -0.1%                                | 3.2%              | 0.1%                 | 3.1%      |
| Over 75 beds                | 42                       | 0.0%                                 | 3.2%              | 1.5%                 | 4.8%      |
3. Results

Table 15 above displays the results of our analysis. The table groups IPFs into the categories listed below based on characteristics provided in the Provider of Services (POS) file, the IPF provider specific file, and cost report data from HCIS:

- Facility Type
- Teaching Status Adjustment
- Location
- Census Region
- Size

The top row of the table shows the overall impact on the 1,712 IPFs included in the analysis.

In column 3, we present the effects of the budget-neutral update to the labor-related share and the wage index adjustment under the CBSA geographic area definitions announced by OMB in June 2003. This is a comparison of the simulated RY 2008 payments under the FY 2007 hospital wage index under CBSA classification and associated labor-related share to the simulated RY 2007 payments under the FY 2006 hospital wage index under CBSA classifications and associated labor-related share. There is no projected change in aggregate payments to IPFs, as indicated in the first row of column 3.

There would, however, be small distributional effects among different categories of IPFs. For example, rural non-profit IPFs will experience a 0.3 percent decrease in payments. IPFs located in the Mountain region will receive the largest increase of 0.5 percent.

In column 4, we present the effects of the market basket update to the IPF PPS payments by applying the TEFRA and PPS updates to payments under the revised budget neutrality factor and labor-related share and wage index under CBSA classification. In the aggregate this update is projected to be a 3.2 percent increase in overall payments to IPFs.

In column 5, we present the effects of the payment change in transition blend percentages to the third year of the transition (TEFRA Rate Percentage = 25 percent, IPF PPS Federal Rate Percentage = 75 percent) from the second year of the transition (TEFRA Rate Percentage = 50 percent, IPF PPS Federal Rate Percentage = 50 percent) of the IPF PPS under the revised budget neutrality factor, labor-related share and wage index under CBSA classification, and TEFRA and PPS updates to RY 2007. The overall aggregate effect, across all hospital groups, is projected to be a 0.1 percent decrease in payments to IPFs. There are distributional effects of these changes among different categories of IPFs. Government psychiatric hospitals will receive the largest increase, with urban government hospitals receiving an 8.7 percent increase and rural government hospitals receiving an 8.8 percent increase. Alternatively, psychiatric units with fewer than 12 beds will receive the largest decrease of 4.4 percent.

Column 6 compares our estimates of the changes reflected in this notice for RY 2008, to our estimates of payments for RY 2007 (without these changes). This column reflects all RY 2008 changes relative to RY 2007 (as shown in columns 3 through 5). The average increase for all IPFs is approximately 3.1 percent. This increase includes the effects of the market basket updates resulting in a 3.2 percent increase in total RY 2008 payments and a 0.1 percent decrease in RY 2008 payments for the transition blend.

Overall, the largest payment increase is projected to be among government IPFs. Urban and rural government psychiatric hospitals will receive a 12.4 percent increase. Rural non-profit IPFs will receive a 0.1 percent decrease and psychiatric units with fewer than 12 beds will receive a 1.3 percent decrease.

It is important to note that the projected impact on government IPFs has decreased from last year even though they are receiving a greater percentage of PPS payments in their transition blend. We believe the primary reason for this decrease is that the first “year” under the IPF PPS was actually 18 months in order to move the update for the IPF PPS to July 1 each year. As a result, the market basket increase and payments were projected to be greater. Subsequent updates are for a 12-month period and are of a smaller magnitude.

In addition, the basis of payment under the TEFRA payment system was an IPF’s fixed average cost per discharge. Thus, when the cost of a patient’s care exceeded the average cost per discharge, psychiatric units of acute care hospitals that were not generally set up for patients with long-term psychiatric care needs often transferred these patients to government IPFs. Also, government and other freestanding IPFs that were not usually staffed to accommodate patients with comorbid medical conditions typically transferred these patients to psychiatric units of acute care hospitals. The IPF PPS, which provides comorbidity adjustments and is a per diem system, eliminates certain incentives to transfer. We believe that certain categories of IPFs are expected to receive increases in payment based on their ability to manage their longer-term patients as well as treat their more medically intensive cases.

4. Effect on the Medicare Program

Based on actuarial projections resulting from our experience with other PPSs, we estimate that Medicare spending (total Medicare program payments) for IPF services over the next 5 years would be as follows:

<table>
<thead>
<tr>
<th>Rate year</th>
<th>Dollars in millions</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 1, 2007 to June 30, 2008</td>
<td>$4,245</td>
</tr>
<tr>
<td>July 1, 2008 to June 30, 2009</td>
<td>4,440</td>
</tr>
<tr>
<td>July 1, 2009 to June 30, 2010</td>
<td>4,606</td>
</tr>
<tr>
<td>July 1, 2010 to June 30, 2011</td>
<td>4,803</td>
</tr>
<tr>
<td>July 1, 2011 to June 30, 2012</td>
<td>5,032</td>
</tr>
</tbody>
</table>

These estimates are based on the current estimate of increases in the RPL market basket as follows:
- 3.2 percent for RY 2008
- 3.2 percent for RY 2009
- 2.8 percent for RY 2010
- 3.1 percent for RY 2011
- 3.2 percent for RY 2012

We estimate that there would be a change in fee-for-service Medicare beneficiary enrollment as follows:
- -0.1 percent in RY 2008
- 0.7 percent in RY 2009
- 0.3 percent in RY 2010
- 0.6 percent in RY 2011
- 1.1 percent in RY 2012

5. Effect on Beneficiaries

Under the IPF PPS, IPFs will receive payment based on the average resources consumed by patients for each day. We do not expect changes in the quality of care or access to services for Medicare beneficiaries under the RY 2008 IPF PPS. In fact, we believe that access to IPF services will be enhanced due to the IPF PPS’s ability to improve the quality of care for Medicare beneficiaries. The IPF PPS provides our best estimate of the increase in Medicare payments under the IPF PPS as a result of the changes presented in this notice based on the data for 1,712 IPFs in our database. All expenditures are classified as transfers to Medicare providers (that is, IPFs).

C. Accounting Statement

As required by OMB Circular A-4 (available at http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf), in Table 17 below, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this notice. This table provides our best estimate of the increase in Medicare payments under the IPF PPS as a result of the changes presented in this notice based on the data for 1,712 IPFs in our database. All expenditures are classified as transfers to Medicare providers (that is, IPFs).
TABLE 17.—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES, FROM THE 2007 IPF PPS RY TO THE 2008 IPF PPS RY

<table>
<thead>
<tr>
<th>Category</th>
<th>Transfers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annualized Monetized Transfers.</td>
<td>$130.</td>
</tr>
<tr>
<td>From Whom To Whom?</td>
<td>Federal Government To IPFs Medicare Providers.</td>
</tr>
</tbody>
</table>

D. Conclusion

This notice does not initiate any policy changes with regard to the IPF PPS; rather, it simply provides an update to the rates for RY 2008 using established methodologies. In accordance with the provisions of Executive Order 12866, this rule was previously reviewed by OMB.

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)


Leslie V. Norwalk,
Acting Administrator, Centers for Medicare & Medicaid Services.


Michael O. Leavitt,
Secretary.

BILLING CODE 4120–01–P
Addendum A--Rate and Adjustment Factors

Per Diem Rate:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal Per Diem Base Rate</td>
<td>$614.99</td>
</tr>
<tr>
<td>Labor Share (0.75788)</td>
<td>$466.09</td>
</tr>
<tr>
<td>Non-Labor Share (0.24212)</td>
<td>$148.90</td>
</tr>
</tbody>
</table>

Fixed Dollar Loss Threshold Amount:

$6488

Wage Index Budget Neutrality Factor:

1.0014

National Rural and Urban Cost-to-Charge Ratio Medians and Ceilings:

<table>
<thead>
<tr>
<th>Area</th>
<th>Median</th>
<th>Ceiling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural</td>
<td>0.71</td>
<td>1.7255</td>
</tr>
<tr>
<td>Urban</td>
<td>0.55</td>
<td>1.7947</td>
</tr>
</tbody>
</table>

Facility Adjustments:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural Adjustment Factor</td>
<td>1.17</td>
</tr>
<tr>
<td>Teaching Adjustment Factor</td>
<td>0.5150</td>
</tr>
<tr>
<td>Wage Index</td>
<td>Pre-reclassified Hospital Wage Index (FY2007)</td>
</tr>
</tbody>
</table>

Cost of Living Adjustments (COLAs):

<table>
<thead>
<tr>
<th>Alaska</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Anchorage</td>
<td>1.24</td>
</tr>
<tr>
<td>Fairbanks</td>
<td>1.24</td>
</tr>
<tr>
<td>Juneau</td>
<td>1.24</td>
</tr>
<tr>
<td>Rest of Alaska</td>
<td>1.25</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hawaii</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Honolulu County</td>
<td>1.25</td>
</tr>
<tr>
<td>Hawaii County</td>
<td>1.17</td>
</tr>
<tr>
<td>Kauai County</td>
<td>1.25</td>
</tr>
<tr>
<td>Maui County</td>
<td>1.25</td>
</tr>
<tr>
<td>Kalawao County</td>
<td>1.25</td>
</tr>
</tbody>
</table>

Patient Adjustments:

| ECT – Per Treatment | $264.77       |
### Variable Per Diem Adjustments:

<table>
<thead>
<tr>
<th>Day 1 -- Facility Without a Qualifying Emergency Department</th>
<th>Adjustment Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 2</td>
<td>1.12</td>
</tr>
<tr>
<td>Day 3</td>
<td>1.08</td>
</tr>
<tr>
<td>Day 4</td>
<td>1.05</td>
</tr>
<tr>
<td>Day 5</td>
<td>1.04</td>
</tr>
<tr>
<td>Day 6</td>
<td>1.02</td>
</tr>
<tr>
<td>Day 7</td>
<td>1.01</td>
</tr>
<tr>
<td>Day 8</td>
<td>1.01</td>
</tr>
<tr>
<td>Day 9</td>
<td>1.00</td>
</tr>
<tr>
<td>Day 10</td>
<td>0.99</td>
</tr>
<tr>
<td>Day 11</td>
<td>0.99</td>
</tr>
<tr>
<td>Day 12</td>
<td>0.99</td>
</tr>
<tr>
<td>Day 13</td>
<td>0.99</td>
</tr>
<tr>
<td>Day 14</td>
<td>0.98</td>
</tr>
<tr>
<td>Day 16</td>
<td>0.97</td>
</tr>
<tr>
<td>Day 17</td>
<td>0.97</td>
</tr>
<tr>
<td>Day 18</td>
<td>0.96</td>
</tr>
<tr>
<td>Day 19</td>
<td>0.95</td>
</tr>
<tr>
<td>Day 20</td>
<td>0.95</td>
</tr>
<tr>
<td>Day 21</td>
<td>0.95</td>
</tr>
<tr>
<td>After Day 21</td>
<td>0.92</td>
</tr>
</tbody>
</table>

### Age Adjustments:

<table>
<thead>
<tr>
<th>Age (in years)</th>
<th>Adjustment Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 45</td>
<td>1.00</td>
</tr>
<tr>
<td>45 and under 50</td>
<td>1.01</td>
</tr>
<tr>
<td>50 and under 55</td>
<td>1.02</td>
</tr>
<tr>
<td>55 and under 60</td>
<td>1.04</td>
</tr>
<tr>
<td>60 and under 65</td>
<td>1.07</td>
</tr>
<tr>
<td>65 and under 70</td>
<td>1.10</td>
</tr>
<tr>
<td>70 and under 75</td>
<td>1.13</td>
</tr>
<tr>
<td>75 and under 80</td>
<td>1.15</td>
</tr>
<tr>
<td>80 and over</td>
<td>1.17</td>
</tr>
</tbody>
</table>

### DRG Adjustments:

<table>
<thead>
<tr>
<th>DRG</th>
<th>DRG Definition</th>
<th>Adjustment Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRG 424</td>
<td>Procedure with principal diagnosis of mental illness</td>
<td>1.22</td>
</tr>
<tr>
<td>DRG 425</td>
<td>Acute adjustment reaction</td>
<td>1.05</td>
</tr>
<tr>
<td>DRG 426</td>
<td>Depressive neurosis</td>
<td>0.99</td>
</tr>
<tr>
<td>DRG 427</td>
<td>Neurosis, except depressive</td>
<td>1.02</td>
</tr>
<tr>
<td>DRG 428</td>
<td>Disorders of personality</td>
<td>1.02</td>
</tr>
<tr>
<td>DRG 429</td>
<td>Organic disturbances</td>
<td>1.03</td>
</tr>
<tr>
<td>DRG</td>
<td>DRG Definition</td>
<td>Adjustment Factor</td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------------------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>DRG 430</td>
<td>Psychosis</td>
<td>1.00</td>
</tr>
<tr>
<td>DRG 431</td>
<td>Childhood disorders</td>
<td>0.99</td>
</tr>
<tr>
<td>DRG 432</td>
<td>Other mental disorders</td>
<td>0.92</td>
</tr>
<tr>
<td>DRG 433</td>
<td>Alcohol/Drug use Leave against Medical Advice (LAMA)</td>
<td>0.97</td>
</tr>
<tr>
<td>DRG 521</td>
<td>Alcohol/Drug use with comorbid conditions</td>
<td>1.02</td>
</tr>
<tr>
<td>DRG 522</td>
<td>Alcohol/Drug use without comorbid conditions</td>
<td>0.98</td>
</tr>
<tr>
<td>DRG 523</td>
<td>Alcohol/Drug use without rehabilitation</td>
<td>0.88</td>
</tr>
<tr>
<td>DRG 12</td>
<td>Degenerative nervous system disorders</td>
<td>1.05</td>
</tr>
<tr>
<td>DRG 23</td>
<td>Non-traumatic stupor &amp; coma</td>
<td>1.07</td>
</tr>
</tbody>
</table>

**Comorbidity Adjustments:**

<table>
<thead>
<tr>
<th>Comorbidity</th>
<th>Adjustment Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities</td>
<td>1.04</td>
</tr>
<tr>
<td>Coagulation Factor Deficit</td>
<td>1.13</td>
</tr>
<tr>
<td>Tracheostomy</td>
<td>1.06</td>
</tr>
<tr>
<td>Eating and Conduct Disorders</td>
<td>1.12</td>
</tr>
<tr>
<td>Infectious Diseases</td>
<td>1.07</td>
</tr>
<tr>
<td>Renal Failure, Acute</td>
<td>1.11</td>
</tr>
<tr>
<td>Renal Failure, Chronic</td>
<td>1.11</td>
</tr>
<tr>
<td>Oncology Treatment</td>
<td>1.07</td>
</tr>
<tr>
<td>Uncontrolled Diabetes Mellitus</td>
<td>1.05</td>
</tr>
<tr>
<td>Severe Protein Malnutrition</td>
<td>1.13</td>
</tr>
<tr>
<td>Drug/Alcohol Induced Mental Disorders</td>
<td>1.03</td>
</tr>
<tr>
<td>Cardiac Conditions</td>
<td>1.11</td>
</tr>
<tr>
<td>Gangrene</td>
<td>1.10</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>1.12</td>
</tr>
<tr>
<td>Artificial Openings – Digestive &amp; Urinary</td>
<td>1.08</td>
</tr>
<tr>
<td>Severe Musculoskeletal &amp; Connective Tissue Diseases</td>
<td>1.09</td>
</tr>
<tr>
<td>Poisoning</td>
<td>1.11</td>
</tr>
</tbody>
</table>
Addendum B—RY 2008 CBSA Wage Index Tables

In this addendum, we provide Tables 1 and 2 which indicate the CBSA-based wage index values for urban and rural providers.

Table 1--RY 2008 Wage Index For Urban Areas Based On CBSA Labor Market Areas

<table>
<thead>
<tr>
<th>CBSA Code</th>
<th>Urban Area (Constituent Counties)</th>
<th>Wage Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>10180</td>
<td>Abilene, TX Callahan County, TX Jones County, TX Taylor County, TX</td>
<td>0.8000</td>
</tr>
<tr>
<td>10380</td>
<td>Aguadilla-Isabela-San Sebastián, PR Aguada Municipio, PR Aguadilla Municipio, PR Añasco Municipio, PR Isabela Municipio, PR Lares Municipio, PR Moca Municipio, PR Rincón Municipio, PR San Sebastián Municipio, PR</td>
<td>0.3915</td>
</tr>
<tr>
<td>10420</td>
<td>Akron, OH Portage County, OH Summit County, OH</td>
<td>0.8654</td>
</tr>
<tr>
<td>10500</td>
<td>Albany, GA Baker County, GA Dougherty County, GA Lee County, GA Terrel County, GA Worth County, GA</td>
<td>0.8991</td>
</tr>
<tr>
<td>10580</td>
<td>Albany-Schenectady-Troy, NY Albany County, NY Rensselaer County, NY Saratoga County, NY Schenectady County, NY Schoharie County, NY</td>
<td>0.8720</td>
</tr>
<tr>
<td>CBSA Code</td>
<td>Urban Area (Constituent Counties)</td>
<td>Wage Index</td>
</tr>
<tr>
<td>----------</td>
<td>----------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>10740</td>
<td>Albuquerque, NM</td>
<td>0.9458</td>
</tr>
<tr>
<td></td>
<td>Bernalillo County, NM</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Santa Fe County, NM</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Torrance County, NM</td>
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<tr>
<td></td>
<td>Valencia County, NM</td>
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<tr>
<td>10780</td>
<td>Alexandria, LA</td>
<td>0.8006</td>
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<tr>
<td></td>
<td>Grant Parish, LA</td>
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<tr>
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|           | Galveston County, TX             |            |
|           | Harris County, TX                |            |
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|           | Montgomery County, TX            |            |
|           | San Jacinto County, TX           |            |
|           | Waller County, TX                |            |
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            | Greenup County, KY               | 0.8997     |
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| 26820     | Idaho Falls, ID
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Moniteau County, MO  
Osage County, MO | 0.8332     |
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Carter County, TN  
Unicoi County, TN  
Washington County, TN | 0.8043     |
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Cambria County, PA                         | 0.8620     |
| 27860     | Jonesboro, AR  
Craighead County, AR  
Poinsett County, AR | 0.7662     |
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Jasper County, MO  
Newton County, MO | 0.8605     |
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Kalamazoo County, MI  
Van Buren County, MI | 1.0704     |
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Kankakee County, IL | 1.0083     |
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St. Clair County, IL
Crawford County, MO
Franklin County, MO
Jefferson County, MO
Lincoln County, MO
St. Charles County, MO
St. Louis County, MO
Warren County, MO
Washington County, MO
St. Louis City, MO | 0.9005 |
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Marion County, OR
Polk County, OR | 1.0438 |
| 41500     | Salinas, CA
Monterey County, CA | 1.4337 |
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Somerset County, MD
Wicomico County, MD | 0.8953 |
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Salt Lake County, UT
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Tooele County, UT | 0.9402 |
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*At this time, there are no hospitals located in this urban area on which to base a wage index. Therefore, the urban wage index value is based on the average wage index for all urban areas within the State.*

### Table 2--RY 2008 WAGE INDEX BASED ON CBSA LABOR MARKET AREAS FOR RURAL AREAS

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1 All counties within the State are classified as urban, with the exception of Massachusetts and Puerto Rico. Massachusetts and Puerto Rico have areas designated as rural; however, no short-term, acute care hospitals are located in the area(s) for RY 2008. Because more recent data are not available for those areas, we are using last year's wage index value.